Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0377	A. BUILDING _____ B. WING _____	C 08/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE TOO RESIDENTIAL CARE HOME	69 1/2 ALLEN STREET RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite complaint investigation was conducted on 08/13/09 by the Division of Licensing and Protection. The following deficiencies were cited.	R100	RECEIVED SEP - 1 2009	
R167 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the nurse failed to develop a written plan for the use of the PRN (as needed) psychoactive medications for 1 applicable resident. (Resident #1) 1. Per review on 8/13/09, the care plan for Resident #1 does not describe the specific behaviors for the use of the psychoactive medication, Risperdal 0.5 mg. prescribed by the physician to be given orally twice daily PRN. Although the behavior plan dated 8/11/09	R167	R167 The Care plan and written behavior plans were Amended to include specific behaviors and situations that warrant the use of the PRN dose of Risperdal. Frequent monitoring of written plans is expected as behavior patterns and/or	8/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Pamela Patto TITLE Owner/Administrator (X6) DATE 8/29/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0377	A. BUILDING _____ B. WING _____	C 08/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE TOO RESIDENTIAL CARE HOME	69 1/2 ALLEN STREET RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R167	Continued From page 1 describes self abusive behaviors and redirection, it does not specifically address the indication for when the Risperdal showed be administered.	R167	medications change. This is the responsibility of the managers and RN.	
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide and maintain a safe environment. Findings include: 1. Per interview on 8/13/09 at 10:20 AM the manager/owner confirmed although aware of Resident #1's exit seeking and ability to remove window screens, creating a safety hazard for the resident, who has cognition and memory impairment, no action was taken to secure the screens. Per review on 8/13/09 of "Comment Sheets" staff describe Resident #1 on 8/6/09 as "...wandering quite a bit.....At one point she taken the screen out of her window and was standing on her bed trying to climb out....then found (the resident) in the sunroom, trying to climb out of the window which she had taken the screen out of....". At 9:25 AM with a staff member, the casement windows (measuring approximately 2.5 ft. wide and 4 ft in length) in Resident #1's room were observed. The screens were noted to be easily removable creating an accessible egress for the resident from the facility. The casement window in the sunroom where the resident attempted to	R266 R 266	9/3/09 P.O.C Accepted D. Deentosh As the Surveyor has stated all window screens were secured immediately. The Sunroom window is blocked with an air Conditioner and the arm repaired. Supervisors have been reminded of the importance of reporting any broken fixtures etc.	8/13

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0377	A. BUILDING ____ B. WING ____	C 08/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE TOO RESIDENTIAL CARE HOME	69 1/2 ALLEN STREET RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R266	Continued From page 2 exit on 8/6/09 was observed to be broken creating an expandable space suitable for Resident #1 to attempt an exit. Per interview, the manager confirmed although aware of the issues with the screens, staff had not informed her of the broken window in the sunroom.	R266		
	During the onsite, the facility manager was asked to take immediate action to secure the screens and repair the window in the sunroom. Hardware was purchased and the manager/owner began installation and repair immediately.	R266	The deck is New and fill has been completed, Crushed Stone Now Surrounds the deck exit to ground.	8/15
	2. On 8/13/09 at 10:35 AM accompanied by the manager observations of the back yard, into which the deck off of the dinning room exits, revealed 2 large gaps between the back side of the fence and the ground where soil had eroded measuring approximately 12 to 15 inches in height. In addition, where the bottom step of the deck meets the ground a large whole (approximately 8 inches by 10 inches) was observed, creating a hazard for staff, family and residents who utilize the deck and exit from the deck into the back yard.		Low spots observed between fence and ground were filled immediately and Finished landscaping is expected by Sept 4th when the ground work and plants added should control the washouts that the Land has been prone to mild errosion. 9/3/09 P.OC Accepted [signature]	9/4